U.S. Department of Labor

Office of Administrative Law Judges
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Issue date: 10Aug2001

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In the Matter of

ROBERT YOST,

Case No. 2000-BLA-501

Claimant

v.

CONSOLIDATION COAL COMPANY,

Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,

Party-in-Interest

.....

Appearances:

Robert N. Yost
Pro Se Claimant

Douglas A. Smoot, Esq.
Mary Rich Maloy, Esq.
Jackson and Kelly PLLC
For the Employer

Douglas N. White, Esq.
Office of the Solicitor
For the Director, OWCP

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 et seq. (the "Act"). The Act and implementing regulations, 20 CFR parts 410, 718, 725 and 727 (the "Regulations"), provide compensation and other benefits to: (1) living coal miners who are totally disabled due to pneumoconiosis and their dependents; (2) surviving dependents of coal miners whose death was due to pneumoconiosis; and (3) surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death (for claims filed prior to January 1, 1982). The Act and Regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 CFR § 718.201 (2001). In this case, the Claimant, Robert N. Yost, alleges that he is totally disabled by pneumoconiosis.

In reaching my decision, I have reviewed and considered the entire record pertaining to the claim before me, including all exhibits and the arguments of the parties.

PROCEDURAL HISTORY

The Claimant filed his initial claim on December 28, 1973. DX 22-1. On May 12, 1975, a Claims Examiner notified the Claimant that the medical evidence submitted in support of his claim did not establish that he had pneumoconiosis or that he was totally disabled, but that he could submit additional medical evidence. DX 22-21 at 4-5. On July 31, 1979, a Claims Examiner notified the Claimant that his claim was being reconsidered under the 1977 amendments to the Act. DX 22-21 at 1-3. On October 31, 1979, the Claimant's claim was denied because he did not establish that he had pneumoconiosis caused by coal mine work or that he was totally disabled by the disease. DX 22-22. Though the Claimant requested time to submit more evidence, DX 22-23, and the Claims Examiner gave him until January 31, 1980, DX 22-24, no further evidence appears in the record for this particular claim.

More than one year later, on January 2, 1985, the Claimant filed a duplicate claim. DX 23-1. The Administrative Law Judge ("ALJ") granted the Claimant's request to withdraw this claim in an Order of Dismissal issued on January 4, 1998. DX 23-22. The Claimant requested that his claim be withdrawn because a possibility existed that his former company might call him back to work, and he wanted to attempt to do this coal mine work. DX 23-21. The Director had initially determined that the Claimant did not meet any of the elements of entitlement. DX 23-14.

More than one year after withdrawing his January 2, 1985, claim, on November 14, 1990, the Claimant filed another claim for benefits. DX 24-1. The Claims Examiner initially determined that the Claimant was eligible for benefits. DX 24-18. The Employer controverted the finding, DX 24-19, and on August 29, 1991, the Claims Examiner determined that the Claimant did not have pneumoconiosis caused at least in part by coal mine work and that he was not totally disabled by the disease, DX 24-29. The Claimant requested a hearing before the Office of Administrative Law Judges, DX 24-30,

which was held before Judge Feirtag on July 8, 1992, DX 24-42. On November 9, 1992, the ALJ issued a Decision and Order – Denial of Benefits, in which he concluded that the Claimant had not shown that he had pneumoconiosis. DX 24-47.

The Claimant appealed his claim to the Benefits Review Board, and the Board issued a Decision and Order on February 17, 1995, in which it affirmed in part and vacated and remanded in part the ALJ's decision. DX 24-50. The Board affirmed the ALJ's finding regarding the x-ray evidence of pneumoconiosis. However, the case was remanded because the ALJ had discounted the opinions of physicians regarding the existence of pneumoconiosis based on the fact that the Claimant was still employed at the time of their opinions. The Board noted that this fact was not relevant to a determination regarding the existence of pneumoconiosis, though it would be relevant to a determination regarding total disability. The Board also remanded the case because the ALJ had given less weight to Dr. Rasmussen's opinion, based on his reliance on a positive x-ray reading. The Board noted that Dr. Rasmussen had also found other conditions which could meet the statutory definition of pneumoconiosis. The Board remanded the case for consideration of the existence of pneumoconiosis based on medical opinions. DX 24-50.

The case was assigned to Judge Rosenzweig, who issued a Decision and Order on Remand Denying Benefits on October 2, 1996. The ALJ examined the medical opinion evidence pursuant to 20 CFR § 718.202(a)(4). She concluded that the Claimant had not established the presence of pneumoconiosis. In a footnote, the ALJ found that the Claimant had not established the he was totally disabled by pneumoconiosis or any other respiratory or pulmonary impairment. DX 24-55.

The Claimant filed his current claim on June 25, 1999. DX 1. On December 29, 1999, the District Director initially determined that the Claimant was entitled to benefits under the Act. DX 18. The Employer contested liability and requested a formal hearing before the Office of Administrative Law Judges. DX 19. The claim was referred to the Office of Administrative Law Judges for hearing on February 29, 2000. DX 26.

On April 25, 2000, Judge Morgan issued a Notice of Hearing and Pre-hearing Order, setting the case for hearing on July 19, 2000. On that same date, a letter was sent to the Claimant suggesting that he might wish to seek the services of an attorney. The case was rescheduled for August 16, 2000. On June 5, 2000, the Employer filed a Motion to Dismiss, alleging that the Claimant had failed to cooperate fully during a pulmonary function test ordered by the Employer, thus preventing the Employer from fully examining the Claimant by a physician of its choice. On June 5, 2000, Judge Morgan issued an Order to Show Cause Why Miner's Claim Should Not Be Dismissed. On June 16, 2000, the Employer's attorney advised the Claimant that a pulmonary function test had been scheduled for the Claimant. In compliance with the June 5 Order to Show Cause, the Employer submitted Dr. Hippensteel's explanation of the facts which led him to conclude that the Claimant had been uncooperative in his pulmonary function tests. Via letter of June 16, 2000, the Claimant responded to the June 5 Order, stating that his understanding of the June 5 Order was that, after the Employer

submitted Dr. Hippensteel's explanation, the Claimant could either respond to it or submit to another pulmonary function test. He requested that the ALJ rescind his Order to Show Cause and deny the Employer's Motion to Dismiss. On June 19, 2000 the ALJ issued an Order Denying Motion to Rescind Show Cause Order, in which he ordered the Claimant to either explain in writing whether he did or did not cooperate with Dr. Hippensteel during the April 11, 2000, pulmonary function test, or submit to a retest. Following the issuance of this order, on June 21, 2000, this office received the Employer's response to the Claimant's June 17, 2000, letter. The Employer stated that it had complied with the Show Cause Order and that the Claimant should either submit his response or undergo the re-test, and if he did neither of these things, his claim should be dismissed. On June 26, 2000, the office received a copy of the Claimant's letter to Employer's counsel, in which he stated that he would not attend the June 27, 2000, pulmonary function test. On June 27, 2000, the office received a letter from the Solicitor's office, which stated that the Director did not consent to the dismissal of the claim and that the Claimant had cooperated with the test. The medical exam scheduled for June 27, 2000, was canceled. On July 5, 2000, this office received the Claimant's Explanation of Cooperation During Pulmonary Function Testing on April 11, 2000. Thereafter on July 12, 2000, the ALJ issued an Order Denying Employer's Motion to Dismiss.

On July 24, 2000, the Claimant requested a continuance so that he might obtain representation. An Order of Continuance was issued on July 25, 2000. The case was set for hearing before me on January 16, 2001. On November 21, 2000, I received the Claimant's request for a decision on the record. The Employer did not object to a decision on the record, and, on December 11, 2000, I issued an Order Granting Request for Decision on the Record and Setting Schedule to Complete the Record. Under cover letter of November 9, 2000, the Claimant submitted medical evidence consisting of a medical opinion letter from Dr. Forehand, a pulmonary function test dated August 18, 2000, and Dr. Alexander's curriculum vitae[1]. These items have been marked as Claimant's Exhibit 1, and are hereby admitted into evidence. Under cover letter of February 27, 2001, this office received the Employer's Final Submission of Evidence and Closing Argument. Enclosed were Employer's Exhibits 1 through 23, which are hereby admitted into the record. Director's Exhibits 1 through 26 are also hereby admitted into evidence.

ISSUES

The issues contested by the Employer are:

1. Whether the claim was timely filed.
2. Whether the Claimant was a miner.
3. Whether the Claimant worked as a miner after December 31, 1969.

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[1]In his cover letter, the Claimant stated he was enclosing Dr. Forehand's curriculum vitae, but in actuality, the curriculum vitae included in Claimant's Exhibit 1 is that of Dr. Alexander.

4. How long the Claimant worked as a miner.[2]
5. Whether the Claimant has pneumoconiosis as defined by the Act and the Regulations.
6. Whether the Claimant's pneumoconiosis arose out of coal mine employment.
7. Whether the Claimant is totally disabled.
8. Whether the Claimant's disability is due to pneumoconiosis.
9. The number of Claimant's dependents for purposes of augmentation.
10. Whether the named Employer is the Responsible Operator.
11. Whether the named Employer has secured the payment of benefits.
12. Whether the evidence establishes a material change in conditions pursuant to 20 CFR § 725.309 (2000).

DX 25. The Employer did not address most of these issues in its closing argument; nor will I in this decision, as some issues were resolved in the proceedings on prior claims, and others have no effect on the outcome of the case.

APPLICABLE STANDARDS

This case relates to a "duplicate" claim filed on June 25, 1999. Because the claim at issue was filed after April 1, 1980, the Regulations at 20 CFR Part 718 apply. 20 CFR § 718.2 (2001). Parts 718 (standards for award of benefits) and 725 (procedures) of the Regulations have undergone extensive revisions effective January 19, 2001. 65 Fed. Reg. 79920 et seq. (2000). The Department of Labor has taken the position that as a general rule, the revisions to Part 718 should apply to pending cases because they do not announce new rules, but rather clarify or codify existing policy. *See* 65 Fed. Reg. at 79949-79950, 79955-79956 (2000). Changes in the standards for administration of clinical tests and examinations, however, would not apply to medical evidence developed before January 19, 2001. 20 CFR § 718.101(b) (2001). The new rules specifically provide that some revisions to Part 725 apply to pending cases, while others (including revisions to the rules regarding duplicate claims and modification) do not; for a list of the revised sections which do **not** apply to pending cases, see 20 CFR § 725.2(c) (2001).

On February 9, 2001, the United States District Court for the District of Columbia entered a *Preliminary Injunction Order* in a case challenging certain of the new rules, *National Mining Association, et al., v. Elaine L. Chao, et al.*, No. 1:00CV03086(EGS). Pursuant to ¶ 3 of the *Preliminary Injunction Order*, adjudication of claims pending before the Office of Administrative Law Judges on the effective date of the new regulations was stayed absent a finding, after briefing by the parties, that the new regulations would not affect the outcome of the case. On March 13, 2001, I issued an order to the parties to submit briefs on this issue within ten days, stating that failure of a party to submit a brief would be construed as position that the amended regulations will not affect the

[2]The Director contests this issue as well.

outcome of the claim. The Claimant, the Employer and the Director each filed a brief. The Employer took the position that application of two provisions of the amended regulations, 718.201(c) (latent and progressive disease), and 718.204(a) (disability and non-pulmonary conditions or diseases) will or may affect the outcome of the case because they change the law, and that to proceed would violate the injunction. The Claimant and the Director disagreed. While I was considering the case, on August 9, 2001, the District Court entered its decision upholding the new rules and dissolving the preliminary injunction. The Court specifically found that the rules challenged by the Employer in this case do not change the law and may be applied to pending claims. Slip opinion at 38-39. In this Decision and Order, the "old" rules applicable to this case will be cited to the 2000 edition of the Code of Federal Regulations; the "new" rules will be cited to the 2001 edition.

As noted above, because this claim was filed after April 1, 1980, the Regulations at 20 CFR Part 718 apply. Furthermore, this claim is a duplicate claim. Pursuant to 20 CFR § 725.309 (2000), in order to establish that he is entitled to benefits in a duplicate claim, the Claimant must demonstrate that there has been a "material change in conditions" since the denial of his previous claim such that he now meets the requirements for entitlement to benefits under 20 CFR Part 718. In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. 20 CFR §§ 718.1, 718.202, 718.203 and 718.204 (2001). I must consider the new evidence and determine whether the Claimant has proved at least one of the elements of entitlement previously decided against him. If so, then I must consider whether all of the evidence establishes that he is entitled to benefits. *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358 (4th Cir. 1996).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background

The Claimant worked for Consolidation Coal Company intermittently between 1953 and 1990. DX 2, DX 3, DX 4, DX 12. Because all of the Claimant's work in the mines took place in Virginia or West Virginia, DX 2, the law of the Fourth Circuit applies to this case. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (en banc). The record reflects that on December 15, 1977, the Claimant was awarded a 25% permanent partial disability award for occupational pneumoconiosis by the Workmen's Compensation Fund in West Virginia. DX 5. On November 2, 1999, the Claimant completed a questionnaire for the Operator, in which he answered that he was married to Mary Alice Yost. He described the physical requirements of his last job, which he claimed was general inside labor ending in 1985.[3] This work involved maintaining and moving belt structures, rock dusting, setting

[3]Social Security records reflect that the Claimant actually worked for Consolidation Coal Company in 1989 and 1990. DX 4. I conclude that the Claimant erred in specifying 1985 as the year of his last work, but was describing his last job.

timbers, and shoveling around the belts. His next to last coal mine employment was as a roof bolter, which work he performed for 18 years. This position involved constant exposure to silica and coal dust. He described his medical history, physicians, hospital stays, and past injuries. He indicated that he began smoking at 20, and that he continued to smoke. For the six months prior to completing the questionnaire, the Claimant claimed to have smoked only one to two cigarettes per week. He had previously smoked a pack a day. He indicated a 35-40 year smoking history. DX 16.

Timeliness

The purpose of the Regulation allowing the filing of duplicate claims is "to provide relief from the ordinary principles of finality and res judicata to miners whose physical condition deteriorates." *Lukman v. Director, OWCP*, 896 F.2d 1248, 1253 (10th Cir. 1990). There is no statute of limitations for filing a duplicate claim. 20 CFR § 725.309 (2000); *Andryka v. Rochester Pittsburgh Coal Co.*, 14 B.L.R. 1-34 (1990). The Employer has offered no evidence or argument in support of this issue. I find that the claim is timely.

Length of Employment

The Claimant alleged 25 years of coal mine employment. DX 1, DX 25. In the Claimant's prior claim, the Claimant and Employer stipulated that the Claimant had 23 years of coal mine employment. DX 24-42 at 4-5. At that time, the Claimant had last worked as a miner in 1990. The record in the instant claim does not disclose any further coal mine employment by the Claimant, and the record supports a finding of 23 years of coal mine employment. Accordingly, I find that the Claimant has 23 years of coal mine employment.

Responsible Operator

In the Claimant's last claim, ALJ Feirtag found that Consolidation Coal Company was the Responsible Operator. DX 24-45. As the Claimant has not been employed as a miner since that time, I find that Consolidation Coal Company is appropriately named as the Responsible Operator in the current claim.

Material Change in Conditions

In a duplicate claim, the threshold issue is whether there has been a material change in conditions since the previous claim was denied. The Claimant's previous claim was finally denied by Judge Rosenzweig on October 2, 1996. As will be discussed in more detail below, pulmonary function tests and medical reports indicate that the Claimant now has a pulmonary impairment which is totally disabling. This constitutes a material change in conditions. Because the new evidence establishes that a material change in conditions has occurred, I must consider all of the evidence in the record in reaching my decision whether he is now entitled to benefits. *Lisa Lee Mines v. Director, OWCP*, 57 F.3d 402,

406 (4th Cir. 1995).

Medical Evidence

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The quality standards for chest x-rays and their interpretations performed before January 19, 2001, are found at 20 CFR § 718.102 (2000) and Appendix A of Part 718. The following table summarizes the x-ray findings available in connection with the current claim. Qualifications of physicians are abbreviated as follows: B= NIOSH certified B-reader; BCR= board-certified in radiology; BCP=board-certified in pulmonology; BCI= board-certified in internal medicine. Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B-readers need not be radiologists. Film quality codes are 1, Good; 2, Acceptable, with no technical defect likely to impair classification of the radiograph for pneumoconiosis; 3, Poor, with some technical defect but still acceptable for classification purposes; and 4 or U/R, Unacceptable. The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2000). Small opacities (1, 2, or 3) (in ascending order of profusion) may classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis."

Exhibit No.	X-Ray Date Date Read	Physician/ Qualifications	Film Qu a- lity	ILO-U/C Classification and Interpretation or Impression
DX 10	07/28/99 07/28/99	Forehand B	2	No parenchymal or pleural abnormalities consistent with pneumoconiosis; hyperinflation left unilateral basilar pleural thickening with scarring of parenchyma and blunting of left costophrenic angle.
DX 11	07/28/99 08/25/99	Navani BCR/B	3	0/1, q/t; effusion, pleural thickening.
DX 20	07/28/99 12/08/99	Alexander BCR/B	2	1/1, p/t. Coal Workers' Pneumoconiosis, category p/t, 1/1; emphysema; unilateral chest wall pleural thickening.

Exhibit No.	X-Ray Date Date Read	Physician/ Qualifications	Film Qu a- lity	ILO-U/C Classification and Interpretation or Impression
EX 1	07/28/99 02/17/00	Wiot BCR/B	1	0/1, q/q; no evidence of CWP. Pleural disease at the left costophrenic angle, extending along left lateral chest wall. Disc atelectasis in same area. Not a manifestation of coal dust exposure. Changes in left upper lobe likely post- inflammatory. Atherosclerotic changes in thoracic aorta.
EX 3	07/28/99 03/25/00	Spitz BCR/B	1	0/1. q/q. Linear strands at left base. Pleural disease along left lower lateral chest wall- could be due to inflammatory process or asbestos pleural effusion.
EX 5	7/28/99 5/17/00	Wheeler BCR/B	1	No parenchymal or pleural abnormalities consistent with pneumoconiosis. Probable subtle focal fibrosis or few ill defined nodules in lateral periphery LUL. One tiny calcified granuloma in lateral periphery RUL compatible with TB, unknown activity - probably healed. Minimal hyperinflation lungs compatible w/ deep breath or emphysema/ few linear discoid atelectasis or scars in left lower lung near smooth pleural fibrosis or lower lateral chest wall - blunts and elevates left CPA compatible with healed pneumonia. Tiny calcified granuloma lateral periphery RUL and focal arteriosclerosis aorta. No evidence of silicosis or CWP.
EX 5	7/28/99 5/17/00	Scott BCR/B	1	No parenchymal or pleural abnormalities consistent with pneumoconiosis. Few small peripheral nodules apices compatible with healed TB, activity cannot be excluded. Minimal left CPA - blunting compatible with pleural effusion or fibrosis. Discoid atelectasis or linear scars left lower lung.

Exhibit No.	X-Ray Date Date Read	Physician/ Qualifications	Film Qu a-lity	ILO-U/C Classification and Interpretation or Impression
EX 6	7/28/99 6/2/00	Kim BCR/B	1	No parenchymal or pleural abnormalities consistent with pneumoconiosis. Few small nodular densities in the periphery of upper lung, probably old healed granulomatous process (TB) but active disease can't be ruled out. Blunting of left CP angle probably thickening (fibrosis) or small pl. effusion. Linear atelectasis in left lower lobe.
EX 4	4/11/00 4/11/00	Hippensteel B, BCP, BCI	1	0/1, q/r. Left costophrenic angle blunting. Minimal increase in interstitial markings in lung apices leading to 0/1, q/r classification.
EX 7	04/11/00 06/08/00	Wheeler BCR/B	2	No parenchymal or pleural abnormalities consistent with pneumoconiosis. normal except for a few linear discoid atelectasis or scars in left lower lung and minimal pleural fibrosis blunting and elevating left lateral CPA and tiny calcified granuloma with few small scars in lateral periphery RUL compatible with healed TB.
EX 7	04/11/00 06/06/00	Scott BCR/B	2	No parenchymal or pleural abnormalities consistent with pneumoconiosis; minimal left CPA blunting compatible with pleural fibrosis or effusion; minimal discoid atelectasis or linear scars left lower lung; possible small calcified granuloma right upper lung laterally; hyperinflation lungs: emphysema versus deep breath. No evidence of silicosis/CWP

Exhibit No.	X-Ray Date Date Read	Physician/ Qualifications	Film Qu a-lity	ILO-U/C Classification and Interpretation or Impression
EX 7	04/11/00 06/19/00	Kim BCR/B	2	No parenchymal or pleural abnormalities consistent with pneumoconiosis. linear atelectasis - the left lower lung and prob. pleural fibrosis - left CP angle. Non-specific focal fibrosis in the periphery of both upper lungs. Prob. old healed granulomatous process.
EX 10	04/11/00 06/27/00	Wiot BCR/B	2	0/1. q/q. Significant pleural disease at left base. Not a manifestation of coal dust exposure. Linear stranding consistent with past inflammatory process. Few opacities left upper zone are post-inflammatory. Right upper lung field perfectly clear.
EX 12	04/11/00 07/09/00	Spitz BCR/B	1	0/1, q/q. Linear strands at left lung base. Pleural blunting of left costophrenic angle. Q nodules left upper lung with 0/1 profusion, may be on the basis of prior granulomatous disease. Old inflammatory process at the left base with linear strands and blunted left costophrenic angle.

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV). The following chart summarizes the results of the pulmonary function studies available in connection with the current claim. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. The quality standards for pulmonary function studies performed before January 19, 2001, are found at 20 CFR § 718.103 (2000). The standards require that the studies be accompanied by two or three tracings of each test performed. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must

be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less.

Ex. No. Date Physician	Age Height	FEV_1 Pre-/ Post	MVV Pre-/ Post	FVC Pre-/ Post	Tra- cings	Comp. / Coop.	Qua l- ify	Physician Impression
DX 7 07/28/99 Forehand	65 yrs 71"	1.30 1.48	33 35	2.64 2.59		Good Good	Yes Yes	Moderately severe obstructive ventilatory pattern[4]
EX 4 4/11/00 Hippen- steel	66 yrs 71"	1.81 1.70	39	2.92 3.01			Yes No	Suboptimal peak effort/ flow, underestimate of true function. Lung volumes show air trapping with no restriction. MVV invalid due to marked variability in total volumes and effort. Normal diffusion.
CX 1 08/18/00 Forehand	66 yrs 71"	1.61 1.87	54 75	3.09 3.58		cooper ative. good efforts	Yes Yes	Partially reversible obstructive ventilatory pattern.

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled. The quality standards for arterial blood gas studies performed before January 19, 2001, are found at 20 CFR § 718.105 (2000). The following chart summarizes the arterial blood gas studies available in connection with his current claim. The blood sample is analyzed for the percentage of oxygen (PO_2) and the percentage of carbon dioxide (PCO_2) in the blood. A "qualifying" arterial blood gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests

[4]Dr. Michos determined that the vents were acceptable, but that there was suboptimal MVV performance. DX 7.

with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 CFR § 718.105(b) (2000).

Exhibit Number	Date	Physician	PCO_2 at rest exercise	PO_2 at rest exercise	Qualify	Physician Impression
DX 7, 9	07/28/99	Forehand	38 35	61 76	Yes No	No evidence of resting or exercise-induced arterial hypoxemia.
EX 4	04/11/00	Hippensteel	41.4 36.2	81.7 79.8	No No	Normal gas exchange at rest. Carboxyhemoglobin level elevated consistent with 1 pack/day smoking. Normal oxygenation with exercise.

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 CFR §§ 718.202(a)(4) (2001). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2001). Where total disability cannot be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. 20 CFR § 718.204(b)(2)(iv) (2001). With certain specified exceptions, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 CFR § 718.204(c)(2) (2001). Quality standards for reports of physical examinations performed before

January 19, 2001, are found at 20 CFR § 718.104 (2000). The record contains the following medical opinions submitted in connection with the current claim.

Dr. J. Randolph Forehand

On July 28, 1999, Dr. J. Randolph Forehand examined the Claimant on behalf of the Director. Dr. Forehand's examination included the taking of medical, family, and occupational histories; a chest x-ray; a vent study; an arterial blood gas study; and an EKG. Based on the Claimant's history, pulmonary function studies, and physical examination, Dr. Forehand concluded that the Claimant had both coal workers' pneumoconiosis and chronic bronchitis. The etiology for these conditions was the Claimant's exposure to coal dust as a roof bolter and his cigarette smoking. Dr. Forehand felt that the Claimant had a significant respiratory impairment which did not leave him with sufficient ventilatory capacity to return to his last coal mine employment; the Claimant was permanently and totally disabled. According to Dr. Forehand, the Claimant's 28 years of exposure to coal dust and silica, and in particular his work as a roof bolter, which results in the highest risk of developing Coal workers' pneumoconiosis, contributed to his impairment, as did his cigarette smoking, which impairs the clearance of dust from the lungs and damages the airways. DX 8.

On August 19, 2000, Dr. Forehand reported that he had seen the Claimant on August 18, 2000, at which time he conducted a pulmonary function test. He summarized the spirometry results from July 28, 1999, April 11, 2000, and August 18, 2000, and noted that all of the tests showed a moderately severe obstructive ventilatory pattern. Dr. Forehand acknowledged that others had suggested the Claimant did not cooperate during these tests and that they did not accurately reflect the Claimant's lung function. With regard to the August 18, 2000, test, Dr. Forehand noted that the Claimant was coached prior to its administration, and that while each blow on the test caused the Claimant to wheeze, his volume-time and flow volume curves were still "smooth, consistent and without hesitation, coughing or signs of coming off of the mouthpiece." Dr. Forehand observed that the August 18 values met the Department of Labor's disability guidelines and were similar to the values obtained on the July 28, 1999, and April 11, 2000, values. He concluded that the Claimant did not have the ventilatory capacity to perform his last coal mine employment as a roof bolter and belt cleaner. CX 1.

Dr. Hippensteel

On May 15, 2000, Dr. Hippensteel authored a report in which he summarized and discussed the Claimant's medical data and his examination and testing of the Claimant. Dr. Hippensteel is board-certified in pulmonary disease and internal medicine and is a B-reader. Dr. Hippensteel examined the Claimant and took a medical, occupational, and family history. A chest x-ray, pulmonary function studies, arterial blood gas studies and an electrocardiogram were conducted. The x-ray showed a minimal increase in interstitial lung apices, and blunting at the costophrenic angle; it did not indicate pneumoconiosis. He felt that the Claimant exhibited suboptimal peak effort on his spirometry, and thus the values were an underestimate of his true function. The Claimant's lung volumes indicated air trapping with no restriction, and the marked variability in tidal volumes and effort on the MVV made the MVV invalid. His diffusion was normal, and his arterial blood gas studies showed normal gas exchange. His carboxyhemoglobin level was elevated to a level consistent with a one-pack-per-day

smoking habit, indicating that the Claimant had understated the extent of his smoking habit. His exercise blood gas levels were normal. The EKG showed a nonspecific ST-T wave abnormality inferiorly.

Based on this examination and the data obtained, Dr. Hippensteel found insufficient evidence to diagnose coal workers' pneumoconiosis. The extent of the Claimant's obstructive disease could not be determined because of his suboptimal effort on the tests. The Claimant had no diffusion or gas exchange impairment, though he did have "a small amount of obstructive lung disease without any restriction that is likely related to his continuing smoking habit and is unrelated to his prior coal dust exposure." Dr. Hippensteel was unsure if the Claimant's pulmonary impairment would prevent him from performing heavy manual labor. Dr. Hippensteel did not think the Claimant had industrial bronchitis, and felt that his periodic bronchitis episodes were related to his smoking. His musculoskeletal impairment from his leg injuries would add to his impairment as a whole man. EX 4.

Dr. Hippensteel reviewed additional medical records dating from 1964 forward, and concluded that his own findings were valid. He found that the Claimant's function had worsened since leaving the mines, based on the Claimant's continued smoking. He could not be sure of the extent of the deterioration because of lack of valid efforts on the pulmonary function tests. Weighing against a finding of coal workers' pneumoconiosis were the lack of gas exchange or diffusion impairment, the temporal correlation between his impairment and his smoking, and the partial reversibility of the Claimant's impairments. He would find that the Claimant did not have coal workers' pneumoconiosis even if the chest x-rays were positive. While Dr. Hippensteel could not say whether from a pulmonary standpoint the Claimant could return to work in the mines, he did think that the Claimant had not suffered an impairment from his coal dust exposure that would prevent him from returning to the mines. His impairment arose from his continued cigarette smoking. EX 4.

On June 14, 2000, Dr. Hippensteel explained in a letter that he found the April 11, 2000, pulmonary function test invalid because the Claimant did not give sufficient or consistent enough effort to give a true measure of his pulmonary function. The Claimant's peak expiratory flow varied by more than 20% in his pre-bronchodilator efforts and by more than 30% in his post-bronchodilator efforts. He noted that the same problem was present with Dr. Forehand's July 28, 1999, pulmonary function studies. He also found the Claimant' self-reported inability to do the lung volume test due to shortness of breath and his failure to maintain a seal with his lips on the machine, showed that he was not cooperating. EX 16.

Dr. Hippensteel was deposed on July 11, 2000. In preparation for the deposition, Dr. Hippensteel reviewed the reports of Drs. Fino, Loudon and Morgan. He also reviewed x-ray interpretations of both the April 11, 2000, and July 28, 1999 x-rays. Dr. Hippensteel summarized his findings from his evaluation of the Claimant. He noted that the Claimant's carboxyhemoglobin level did not correlate with the Claimant's reported level of smoking. The Claimant's breath sounds showed minimal rhonchi but no rales, indicating mild airway irritation but no other findings. The Claimant's chest

x-ray was insufficient to find pneumoconiosis. His interpretation of the April 11, 2000, x-ray was very close to Dr. Wiot's interpretation of that same x-ray. Dr. Hippensteel discussed Dr. Wiot's findings on x-ray, in which Dr. Wiot noted pleural disease in the left base with linear stranding consistent with a past inflammatory process. Dr. Hippensteel interpreted this finding as related to pleural changes that he had found in the left costophrenic angle. He explained that Dr. Wiot noted that this process, which is unrelated to pneumoconiosis, could have caused the changes noted in the left apex, which would also not be related to coal workers' pneumoconiosis.

Dr. Hippensteel testified that he could not get valid results for some of the pulmonary function studies. He noted a June 14, 2000, letter to the ALJ in which he discussed his inability to get valid results and the Claimant's inability to give consistent efforts, as required by the regulations. He noted that the Claimant did not give consistent efforts, as supported by the data, and did not keep his mouth sealed over a tube to accurately perform the lung volume study. He also invalidated Dr. Forehand's spirometry. He disagreed with Dr. Michos' finding that the tracings were acceptable except for a suboptimal MVV. He agreed with Dr. Morgan's findings on the subject of the pulmonary function tests. Dr. Forehand's resting arterial blood gas study showed minimal hypoxemia and a normal exercise response. Dr. Hippensteel's arterial blood gas studies showed normal gas exchange at rest and a submaximal exercise test, because the Claimant did not reach anaerobic threshold. The Claimant did not have a real drop in his pO2 level. The diffusion capacity test was valid and showed normal diffusion when corrected for alveolar volume, which is based on the quality of the breath taken for the test. It would have been higher if the Claimant did not have an elevated carboxyhemoglobin level. Emphysema causes a diffusion impairment and gas exchange impairment with exercise, so Dr. Hippensteel did not believe the Claimant had emphysema. Dr. Forehand did not do a diffusion capacity study, which Dr. Hippensteel thinks is helpful because it can differentiate between different diagnoses: coal workers' pneumoconiosis and emphysema affect diffusion, but bronchitis does not affect diffusion. In this case, the normal diffusion showed that the Claimant did not have pneumoconiosis, despite invalid spirometry.

Based on his evaluation of the Claimant and his review of the other medical reports and data, Dr. Hippensteel did not believe that the Claimant had coal workers' pneumoconiosis, as it is medically or legally defined. He also ruled out the diagnosis of industrial bronchitis, because industrial bronchitis subsides within several months of leaving the mines and because the Claimant's cough was productive of sputum less than one-fourth of the time, which does not meet the definition of chronic bronchitis. Based upon the valid data that Dr. Hippensteel had before him, he felt that the Claimant had the respiratory capacity to return to his last coal mine employment. The Claimant did have some level of obstructive disease, but the extent of this disease could not be determined. He continued to believe that the Claimant's impairment and breathing problems were caused by continued cigarette smoking, rather than by coal dust exposure, as this was supported by the valid objective medical data of record. The Claimant did not have a respiratory impairment caused by, contributed to, or aggravated by his coal dust exposure. EX 13.

In a December 4, 2000, report, Dr. Hippensteel examined additional medical records related to the Claimant, including the results of Dr. Forehand's August 18, 2000 pulmonary function test. He agreed with Dr. Forehand that the Claimant had exhibited better effort on the August 18, 2000 study, though he discussed the variability in effort shown on the test. However, the FEV1 and FVC results for the best two efforts were within 5%. Dr. Hippensteel noted that these results were the best obtained for the Claimant and showed more reversibility post-bronchodilator. This level of improvement was indicative of an asthmatic response based on the AST criteria, which leads to another cause for his obstructive disease besides smoking. He noted that Dr. Forehand did not address the reversibility issue.

Dr. Hippensteel concluded that this pulmonary function test showed sufficient cooperation and consistency to be considered valid. He generally agreed with Dr. Morgan's assessment of the records. After reviewing all of the additional records, Dr. Hippensteel noted that they provided "useful data and corroboration of findings obtained earlier in this individual with a valid spirometry by Dr. Forehand since my examination." Based on the most recent spirometry, Dr. Hippensteel felt the Claimant had a 25% whole man impairment, which would allow him to do "periodic heavy manual labor." He found no evidence that the Claimant's impairment was due to coal workers' pneumoconiosis or dust exposure, based on the variable and partially reversible nature of his impairment. He noted that the Claimant's continued smoking and associated deterioration in function since leaving the mines without developing radiographical evidence of coal workers' pneumoconiosis were consistent with smoking and an asthmatic component, both of which have no relation to his coal mine employment. The Claimant's impairment would be the same had he never worked in the mines. EX 21.

Dr. Fino

Dr. Gregory J. Fino authored a report dated June 26, 2000, in which he summarized all of the Claimant's records and offered an opinion based on those records. Dr. Fino is board-certified in internal medicine and pulmonary disease and is a B-reader. Dr. Fino noted that he had authored a report dated May 21, 1992, in which he concluded that the Claimant did not have coal workers' pneumoconiosis or any other occupationally acquired pulmonary condition. He felt the Claimant had a mild, obstructive ventilatory impairment that was due to smoking rather than dust inhalation. Following his review of the new medical information in conjunction with the other medical information, Dr. Fino's opinion remained unchanged. He did not think the Claimant was disabled due to lung disease. He felt the Claimant's obstructive impairment was due to his smoking and would be the same if he had never been in the mines. EX 8. Dr. Fino authored an additional report dated December 1, 2000, in which he reviewed additional medical information and concluded that it did not change any of his previously-expressed opinions. EX 19.

Dr. Castle

Dr. James R. Castle authored a report dated December 4, 2000. Dr. Castle is board-certified

in pulmonary disease and internal medicine and is a B-reader. He reviewed the Claimant's medical records and reports from 1964 forward. Based on his review of Dr. Forehand's July 28, 1999, examination and testing, Dr. Castle concluded that the spirometric tests were invalid because of less than maximal effort as shown in the peak flows. In his review of Dr. Hippensteel's examination and report on the Claimant, Dr. Castle noted that the spirometric tests showed less than maximal effort, with a less than maximal peak flow. The degree of airway obstruction could not be quantified. Though the lung volumes showed hyperinflation and gas trapping, they might not be valid because the Claimant failed to maintain a seal. With regard to Dr. Forehand's August 18, 2000, pulmonary function study, Dr. Castle noted that the "prebronchodilator spirometry is not valid because the mouth piece was partially obstructed as though with the tongue and the patient did not exhale until plateau was reached." The post-bronchodilator study showed better effort and was probably valid. This study showed moderate airway obstruction, with partial reversibility as evidenced by the significant FEV1 improvement post-bronchodilator. Dr. Castle concluded that the Claimant does not have coal workers' pneumoconiosis. The Claimant's risk factors were coal mining, tobacco abuse, and coronary artery disease. He noted the variability in the Claimant's self-report of smoking history and concluded that the carboxyhemoglobin levels found by Dr. Rasmussen and Dr. Hippensteel supported a finding that the Claimant was smoking at least a pack of cigarettes daily. He noted that the Claimant's x-rays were interpreted by the vast majority of readers as showing no evidence of coal workers' pneumoconiosis. He concluded that the physiological studies showed valid evidence of initially mild airways obstruction after leaving the mining industry, with an increase to moderate, partially reversible airway obstruction while continuing to smoke; this was not consistent with coal workers' pneumoconiosis. He stated:

> When coal workers' pneumoconiosis causes impairment it does so by causing a mixed, irreversible obstructive and restrictive ventilatory defect. The fact that he has no restriction and significant airway reversibility clearly mitigates against this being due to coal workers' pneumoconiosis. This also has developed in the absence of further coal mining employment, but in the presence of an ongoing tobacco abuse habit. This is absolutely typical findings of someone who has tobacco smoke induced chronic obstructive pulmonary disease.

He noted that the ABGs have all shown either normal results or very mild hypoxemia at rest with improvement to normal levels with exercise; the Claimant did not have an abnormal gas transfer mechanism. For all of these reasons, Dr. Castle concluded that the Claimant did not have coal workers' pneumoconiosis, based on the radiographic findings, the physiologic findings, and the arterial blood gas findings. He concluded that the Claimant had a moderate degree of airway obstruction that was not related to coal mine employment or coal dust exposure but was a result of the Claimant's cigarette smoking-induced COPD. The August 18, 2000 pulmonary function tests were probably valid and showed that the Claimant "would not retain the respiratory capacity to perform his usual coal mining employment duties"; however, this was not due to coal mine employment or dust exposure, but rather was due to smoking. Even if the Claimant were determined to have "radiographic evidence of minimal, simple coal workers' pneumoconiosis," Dr. Castle's opinions regarding the Claimant's

impairment would not change because his opinion was not based on the x-rays but on the physiological findings. EX 20.

Dr. Castle was deposed on January 3, 2001. He did not examine the Claimant, but he had extensive data to review. Based on the Claimant's statement while hospitalized, Dr. Castle felt the Claimant had at least a 40-pack-year smoking history, which could cause pulmonary problems such as chronic obstructive pulmonary disease (emphysema and/or chronic bronchitis) and lung cancer, as well as arteriosclerotic cardiovascular disease, peripheral vascular disease and cerebral vascular disease. Upon leaving the mines, the Claimant had mild airway obstruction based on valid pulmonary function tests. The Claimant continued to smoke, and has developed moderate, partially reversible airway obstruction, based on part of the August 2000 pulmonary function test. While Dr. Castle found that the post-bronchodilator pulmonary function test in August 2000 was valid, he did not know if the improvement in the FEV1 was due to effort or reversibility. Because of the invalid prebronchodilator study, asthma could not be diagnosed. He found Dr. Hippensteel's pulmonary function study invalid. The Claimant's blood gases were normal at rest and after exercise. The Claimant had a carboxyhemoglobin level of 4.8% at that time, indicating the Claimant smoked one pack of cigarettes per day. Dr. Hippensteel's data did not show a restrictive impairment: the lung volumes showed hyperinflation and gas trapping, which is the opposite of restriction, and which is consistent with smoking-induced COPD.

Dr. Forehand's 1999 pulmonary function studies were invalid based on submaximal efforts as noted on the peak flows, though there was some degree of reproducibility. Dr. Forehand's blood gas studies showed hypoxemia at rest, with normal levels after exercise. This was not consistent with coal workers' pneumoconiosis, which causes irreversible hypoxemia, but was consistent with tobacco-smoking induced chronic obstructive pulmonary disease. The pulmonary function studies showed reversibility. Coal workers' pneumoconiosis leads to irreversible scarring and would not allow for improvement post-bronchodilator. Dr. Castle noted that the Claimant's x-rays did not show this scarring, though Dr. Castle did not read the x-rays himself. He did review the interpretations, the vast majority of which were negative for pneumoconiosis. Cigarette smoking may not cause any x-ray abnormalities, or it may cause changes from chronic bronchitis, which are seen as irregular opacities in the lower lung zones and read as 0/1 or 1/0, and emphysema. It is possible to have pneumoconiosis that is not radiographically present, but that would show up on a biopsy. However, "[i]n that circumstance, it would show up on a biopsy but would not be of significant enough profusion to be seen radiographically or to cause any significant respiratory abnormalities from a physiologic standpoint." Dr. Castle reviewed the physiologic and radiographic findings and found nothing to support a finding that the Claimant's impairment was due to coal mine dust exposure. He concluded that the cause of the impairment was tobacco smoke-induced airway obstruction. Dr. Castle was familiar with the definition of legal pneumoconiosis, and felt that the Claimant did not have it. His pulmonary function studies and other objective tests were consistent with other patients with similar smoking histories who had never been exposed to coal dust. He did not believe the Claimant retained the respiratory capacity to do his last coal mine employment, because his function would not allow heavy manual labor on a regular basis.

However, this disability was completely due to his tobacco smoking habit. The Claimant would be in the same condition had he never been a miner. EX 23.

Dr. Morgan

Dr. W.K.C. Morgan authored a report dated June 27, 2000, in which he summarized and discussed all of the Claimant's medical records. Dr. Morgan is a B-reader and has held various academic posts in pulmonary disease and occupational medicine. He concluded that the Claimant had mild to moderate airways obstruction that had increased in the past ten years, gradually worsening to at least a moderate level. The Claimant had not used maximal effort on the majority of the pulmonary function studies over the years. The lower values could not be attributed to a lack of understanding or to a disease, since subsequent tests "have been better making it quite apparent that he has not cooperated." However, the Claimant had impaired lung function, but relatively normal arterial blood gases and diffusing capacity. The Claimant's impaired lung function was a result of emphysema and small airways disease caused by his smoking.

Dr. Morgan noted the Claimant's inconsistent statements regarding his smoking history. In 1991, Dr. Rasmussen had found a carboxyhemoglobin level of over 6.5%[5], indicating that the Claimant had smoked at least 1.5 packs of cigarettes daily at that time. Dr. Hippensteel's recent evaluation of the Claimant showed a 4.8% carboxyhemoglobin level. Dr. Morgan concluded that the Claimant had long-standing cigarette smoking history that had led to his airways obstruction. Dr. Morgan found that the Claimant's chest x-ray did not show Coal workers' pneumoconiosis. According to Dr. Morgan, x-ray categories correlate directly with the amount of coal dust deposited in the lungs, with a higher x-ray category indicating the presence of more dust. Therefore, a finding of 0/1 would indicate very little dust in the lungs, which would have no effect on the Claimant's lung function. He concluded that there was insufficient objective evidence to diagnose coal workers' pneumoconiosis. The Claimant had a moderate pulmonary impairment from his cigarette smoking, not from coal mining. Even if the Claimant were found to have simple coal workers' pneumoconiosis, he would find that the Claimant's symptoms were not related to the coal workers' pneumoconiosis. EX 9.

On November 15, 2000, Dr. Morgan reviewed additional medical opinions and evidence and concluded that his findings in his prior report still stood. He agreed with Dr. Hippensteel's June 14, 2000, remarks concerning the validity of some of the pulmonary function studies. He discussed Dr. Hippensteel's July 11, 2000, deposition testimony, noting that the Claimant's arterial blood gas studies taken during exercise involved limited exercise. Dr. Morgan opined that with mild to moderate obstruction, the Claimant should have been able to exercise longer. This is further supported by the Claimant's lack of heart disease and his normal diffusion capacity, with normal gas exchange. While

[5]Dr. Morgan noted that Dr. Rasmussen had not referenced the Claimant's carboxyhemoglobin levels in his report, but the level was included with his records.

coal workers' pneumoconiosis can affect diffusing capacity, the impairment is usually mild, and the patient's diffusing capacity improves on exercise because of better matching of the ventilation and perfusion, except in cases of category 3 pneumoconiosis.

He agreed with Dr. Fino's June 26, 2000, findings regarding the medical information. He noted that the improvement on the FEV1 and FVC from July 28, 1999, to April 2000, could not be attributed to asthma, since the Claimant had never been found to have it, but was instead due to improved effort. Lung function does not improve with age. He agreed with Dr. Stewart's conclusions as contained in his report dated July 19, 2000. Dr. Morgan disagreed with Dr. Stewart's statement in his July 24, 2000, deposition that administration of the bronchodilators explained the difference between the FEV1 and FVC measurements by Dr. Forehand and Dr. Hippensteel. Rather, he felt the difference should be attributed to better effort. He noted that the reversibility of COPD-related obstruction is relatively small. This position was further supported by the normal diffusing capacity in the face of an FEV1 of 1.30; if the Claimant's FEV1 was really that low, the Claimant's diffusing capacity should only have been approximately 50% of predicted. However, he noted that Dr. Stewart had later acknowledged that the disparity between the FEV1's could be explained by poor effort.

As discussed in Dr. Wiot's July 19, 2000, deposition, Dr. Morgan had noted x-ray changes that occur in older, heavy smokers. Irregular opacities are sometimes found in the lower lung zones and are scanty: they do not resemble coal workers' pneumoconiosis opacities.

Based on his review of the additional records, Dr. Morgan's opinions were the same as stated in his June 27, 2000 report. The Claimant had mild to moderate airways obstruction, and the increase in the obstruction over the last ten years could be accounted for by the Claimant's smoking. The Claimant would be able to carry out his last coal mining job were it not for his age. There was insufficient evidence to diagnose coal workers' pneumoconiosis, though Dr. Morgan acknowledged that he had not seen the Claimant's x-rays himself. The Claimant's mild to moderate respiratory impairment could not be attributed to pneumoconiosis or coal dust exposure. He was not totally disabled from his work, but was not suitable for employment due to age. Dr. Morgan's opinion would not change if the Claimant were found to have coal workers' pneumoconiosis. He noted that "[t]he only way it would be possible to diagnose Coal workers' pneumoconiosis was to carry out a lung biopsy, or should Mr. Yost subsequently succumb, then a postmortem examination of the lungs may show microscopic changes of simple Coal workers' pneumoconiosis. The changes of the type I have mentioned that could conceivably be found in Mr. Yost's lungs would in no way lead to respiratory impairment nor would they hasten his demise." EX 17.

On November 21, 2000, Dr. Morgan prepared another report, indicating that he had received additional records from the Claimant dated August 19, 2000. The records contained a table from Dr. Forehand which summarized the Claimant's pulmonary function studies Based on his review of this table, he noted a significant increase in the FVC from July 1999 to August 2000, as well as a 10% increase in the FEV1, with a larger increase of the FEV1 in April 2000. Dr. Morgan stated that:

> [t]he decreased FVC and FEV1 present in Mr. Yost cannot be attributed to coal workers' pneumoconiosis (CWP) or to exposure to coal dust since he stopped working in 1973, that is to say some 26 or 27 years ago.

Dr. Morgan noted that FVC and FEV1 improvement cannot be attributed to natural variation, because they decline with age. The medical evidence supported a diagnosis of COPD, so the improvement must be due to better effort, unless the Claimant had a reversible broncho constriction such as asthma, which is not occupationally related. The MVV was also invalid. Dr. Morgan felt the Claimant's impairment should be classified as mild to moderate based on the improvement from July 1999 to August 2000. Dr. Forehand's finding that the values on the three pulmonary function tests did not significantly differ was "completely incorrect." He noted that the improvement on administration of bronchodilators in the August 2000 test was greater than that seen in coal workers' pneumoconiosis and "would be very uncommon in COPD." He noted that any change in FEV1 would be a large percentage change, and that the tracings were varied, inconsistent, and unacceptable. However, Dr. Morgan felt that there was "no doubt that Mr. Yost has airways obstruction which is probably mild to moderate," as demonstrated by the flow volume loop. The FVC maneuvers showed marked variability, and many of them were aborted after 6 to 7 seconds; he did not believe they complied with the Department of Labor criteria.

Dr. Morgan concluded that the tracings were not acceptable and observed that the lung volumes had increased in the past year, which occurs only in reversible disorders such as asthma. He did not believe the Claimant's efforts were consistent, based on the tracings. Even if the tracings were accepted, the impairment could not be due to coal workers' pneumoconiosis or COPD, which do not improve with time. Coal workers' pneumoconiosis also does not improve with the administration of bronchodilators, and COPD does not show that level of improvement. He attributed the Claimant's improvement in April and August 2000 to better effort on the Claimant's part. He did feel that the Claimant had mild to moderate airways obstruction due to his cigarette smoking. EX 17.

Dr. Loudon

On July 3, 2000, Dr. Robert G. Loudon issued a report, in which he reviewed various reports of other doctors and the new medical evidence in this claim. Dr. Loudon is a professor internal medicine and is the director of the Pulmonary Disease Division at the University of Cincinnati Medical Center. He concluded that there was insufficient objective evidence to support a finding of coal workers' pneumoconiosis. The Claimant's mild degree of chronic obstructive lung disease, while possibly impairing his ability to do heavy manual labor, was not the result of occupational causes. The Claimant was not unable to do his regular coal mining work, and his degree of impairment was "probably no worse than that seen in many of his co-workers of similar age and smoking history." Because of the variability of efforts as shown in the tracings, and the marked reduction in the MVV, it would be difficult to accurately assess the Claimant's work capacity. However, whatever functional

respiratory impairment the Claimant had could not be caused in whole or in part by pneumoconiosis. EX 11.

On November 29, 2000, he reviewed additional medical records and reports, and once again concluded that there was insufficient objective evidence to justify a diagnosis of coal workers' pneumoconiosis, that the Claimant had mild obstructive lung disease which could impair his ability for heavy manual labor but which was not attributable to occupational causes, and that he was not totally disabled from his last coal mine employment. Dr. Loudon felt the Claimant had the same functional ability as his co-workers of a similar age with similar smoking histories. Any functional respiratory impairment the Claimant had was not due to pneumoconiosis, and this would be true even if the Claimant were determined to have pneumoconiosis. EX 18.

Dr. Wiot

Dr. Jerome F. Wiot was deposed on July 19, 2000. Dr. Wiot is a board-certified radiologist and is Professor and Chairman of Radiology at the University of Cincinnati and Director of Radiology at the University of Cincinnati Hospitals, Cincinnati Children's Hospital and Cincinnati Veterans' Administration Hospital. Dr. Wiot discussed extensively his work with the diagnosis of coal workers' pneumoconiosis. He indicated that pneumoconiosis generally appears first in the upper lung fields, more often in the right than left. Coal workers' pneumoconiosis appears as small, rounded or sometimes irregular opacities. The opacities are often of a q size, or t, p, or r. The disease process progresses down the lung, as opposed to asbestos, which begins in the lower fields and moves up. This type of radiographical finding is simple pneumoconiosis. Complicated pneumoconiosis consists of large opacities, which are masses of fibrosis more often occurring in the upper lung fields. They are often symmetrical and are associated with bullae (enlarged air sacs). The large opacities move from the outside of the chest toward the inside. Eggshell calcifications on the lymph nodes appear in about three percent of people with advanced pneumoconiosis. Dr. Wiot testified that when reading an x-ray, he assumes the subject had adequate exposure to develop the disease and he reads the x-ray "tight," meaning that he gives the subject the benefit of the doubt.

He reviewed his readings of x-rays from 1982, 1985, and 1991, noting that none of them showed pneumoconiosis. He discussed his reading of the July 28, 1999, x-ray, which he interpreted as 0/1 with pleural disease at the left costophrenic angle, extending along the left lateral chest wall, and disc atelectasis. Dr. Wiot attributed the changes between 1991 and 1999 to some sort of infectious process. He stated that "pleural disease is not a manifestation of coal dust exposure and pleural disease is usually associated either with an infectious process or something like pulmonary infarction or something like that. . . . [S]ince everything is normal in the past and also his right side is perfectly normal, . . . this is a residual of scarring from this inflammatory process." He disagreed with Dr. Alexander's reading of the 1999 x-ray, noting that there were no p/t opacities and that he did not see thickening of a fissure.

Dr. Wiot read the April 11, 2000, x-ray as 0/1, with pleural disease at the left base and linear stranding down that area, but a perfectly clear right side. He felt this was "undoubtedly a manifestation of post-inflammatory process." He felt the film quality was a 2, due to mottle. Based on these x-rays, Dr. Wiot concluded that the Claimant had "absolutely no evidence of coal workers' pneumoconiosis." His diagnosis of 0/1 was made because he saw a "couple small nodules in his left upper lobe" but that did not mean that he had pneumoconiosis. These nodules were associated with the pleural disease, so they were part of the post-inflammatory process. Dr. Wiot did not believe it was possible to consistently determine from an x-ray whether a person was a smoker, because other disease processes can cause changes similar to those found in smokers. It is possible to see emphysematous process in smokers on x-ray, and CT scans sometimes show squiggles at the base of the lungs related to the subject being emphysematous and a smoker. Opacities in the lungs due to smoking are irregular and are in the bases of the lungs. EX 14.

Dr. Stewart

Dr. Bruce N. Stewart testified by deposition on July 24, 2000. Dr. Stewart is board-certified in internal medicine, pulmonary disease, and sleep disorders and is a B-reader. Dr. Stewart prepared two reports concerning the Claimant. The first was dated May 27, 1992, and Dr. Stewart was deposed on June 22, 1992. More recently, Dr. Stewart prepared a report dated July 19, 2000, which was made a deposition exhibit. In this report, Dr. Stewart reviewed his previous report, as well as other medical reports. He found Dr. Forehand's pulmonary function study valid and indicative of a moderate obstructive defect. The April 11, 2000, pulmonary function study was valid, except for the MVV, which showed marked variability indicative of submaximal efforts and which did not correlate well with the FEV1. He felt that study showed "a moderate obstructive defect with the efforts and results after bronchodilators being somewhat worse." Dr. Stewart concluded that the Claimant did not have coal workers' pneumoconiosis, based on the fact that only one chest x-ray reading was positive and that there is no biopsy evidence. The medical evidence did show a mild to moderate respiratory impairment, though this impairment could not be attributed to coal workers' pneumoconiosis. His conclusion that the Claimant's impairment was not caused by coal workers' pneumoconiosis was based on his determination that the Claimant did not have coal workers' pneumoconiosis and the fact that "there is an adequate explanation for the impairment in the patient's long history of cigarette smoking." Moreover, he did not believe the Claimant was disabled from returning to his coal mining work. His opinions regarding the degree of the Claimant's respiratory disability would not change if the Claimant were found to have pneumoconiosis.

On deposition, Dr. Stewart reiterated that he did not believe the Claimant had coal workers' pneumoconiosis, based on his review of the x-rays, the lack of biopsy evidence, and the lack of a restrictive impairment or rales on examination. He did not believe the Claimant had any respiratory impairment that could be related to coal dust exposure. Dr. Stewart stated that while there was some inconsistency on the pulmonary function study conducted by Dr. Forehand on July 28, 1999, the spirometry portion of the study was valid. He did not think the MVV portion of that study was valid,

because it did not correlate well with the FEV1 and showed variation in efforts. He felt that the difference between the July 28, 1999, FEV1 and the FEV1 obtained by Dr. Hippensteel nine months later was significant. This was significant because it showed a variable disease process that improved with bronchodilators. Though the Claimant's FEV1 improved significantly after bronchodilator in Dr. Forehand's study, it did not do so in Dr. Hippensteel's study. However, he felt that these results showed a reversible component, which does not occur in coal workers' pneumoconiosis. This type of mild to moderate impairment was consistent with cigarette smoking. Dr. Forehand's ABG study showed a slightly reduced PO2 at rest, with dramatic improvement on exercise, which Dr. Stewart felt was consistent with obstructive lung disease such as cigarette smoking. Dr. Hippensteel's ABG showed a normal PO2 level, with no significant change on exercise. The normal diffusion capacity found by Dr. Hippensteel indicated that the Claimant's impairment was not due to emphysema. Dr. Stewart stated:

> [W]hat I'm saying is that this man has obstructive lung disease, not necessarily emphysema but of the chronic bronchitis type, so chronic obstructive pulmonary disease, and you can either have emphysema or chronic bronchitis, and in most cases, there is both. With this man, with a normal diffusion capacity, would indicate that his disorder is primarily chronic bronchitis.

Dr. Stewart attributed the Claimant's damaged airways and bronchial tubes and inflammation and bronchospasm to his cigarette smoking. He agreed with some of the other doctors that the efforts on some of the pulmonary function tests could have been better and that if the Claimant had given better effort on the studies done by Drs. Forehand and Hippensteel, his obstruction might have fallen within the mild range. He stated:

> [F]or me to say that a test is valid does not necessarily mean that I feel that he was giving the best effort. In fact, as I've just said, the results we see indicate that the effort was quite variable and he probably wasn't giving the best effort, but by strict criteria, if you look at the shape of the curves and you look at the absolute values, are they consistent with five percent, and that is the legal guideline that we're using for a valid study, and he did meet that criteria, but it doesn't mean that he couldn't have done better.

Dr. Stewart's understanding was that for Department of Labor purposes, there had to be three tracings, two of which came within 5% of one another.

Dr. Stewart described the Claimant's smoking history as "quite variable," but noted that the objective evidence suggested the Claimant had been smoking "up until recently when Doctor Hippensteel examined him." The 4.8% carboxyhemoglobin level found by Dr. Hippensteel would correlate to smoking 0.5 to 1.0 packs of cigarettes per day. He noted that the Claimant had consistently shown an elevated carboxyhemoglobin level. Dr. Stewart felt the Claimant had the respiratory capacity to return to his usual coal mine work, even with the levels found on the pulmonary function studies done by Drs. Forehand and Hippensteel. He felt the Claimant's obstruction was

caused by his cigarette smoking. He did not believe the Claimant had any impairment or disability caused by, contributed to, or aggravated by his previous coal mine dust exposure. EX 15.

Dr. Stewart wrote an additional report dated December 4, 2000, in which he reviewed additional medical data. With regard to Dr. Forehand's August 18, 2000, pulmonary function test, Dr. Stewart concluded that the pre-bronchodilator portion of the test was invalid because there was more than a 5% difference between two efforts. The post-bronchodilator portion of the test was valid, because there were two values within 5% of each other, and this study shows a moderate obstructive impairment. Dr. Stewart concluded that there was insufficient medical evidence to support a finding of coal workers' pneumoconiosis. He found that the Claimant had a pulmonary or respiratory impairment, but it was not caused by coal workers' pneumoconiosis or dust inhalation. It was caused by the Claimant's cigarette smoking, based on the continued elevated carboxyhemoglobin levels and the pattern of impairment on the pulmonary function testing, which is consistent with COPD. The Claimant has deteriorated in the last ten years, and is totally and permanently disabled from his last coal mine work, which involved working on the belt line and shoveling coal eight hours a day. He did not believe that this impairment was caused by Coal workers' pneumoconiosis. He maintained that it was possible to distinguish between impairments caused by Coal workers' pneumoconiosis and impairments caused by smoking, based on histories, physical examination, pulmonary function studies, and arterial blood gas studies. The Claimant's elevated carboxyhemoglobin levels indicate smoking, and his wheezes and rhonchi are consistent with COPD. The reduction of the FEV1/FVC ratio is not caused by coal workers' pneumoconiosis. Even if the Claimant were found to have coal workers' pneumoconiosis, Dr. Stewart would still maintain his opinion regarding the Claimant's disability and its cause. EX 22.

Total Disability

A miner is considered totally disabled if he has complicated pneumoconiosis, 20 CFR § 304 (2001), or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment, 20 CFR § 204(b) and (c) (2001). The Regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and (5) lay testimony. 20 CFR § 718.204(b) and (d) (2001). Lay testimony may only be used in establishing total disability in cases involving deceased miners, and in a living miner's claim, a finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony. 20 CFR § 718.204(d) (2001); *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-106 (1994). There is no evidence in the record that Mr. Yost suffers from complicated pneumoconiosis or cor pulmonale. Thus I will consider pulmonary function studies, blood gas studies and medical opinions.

The Pulmonary Function Studies

I must determine the reliability of a study based upon its conformity to the applicable quality standards, *Robinette v. Director, OWCP*, 9 B.L.R. 1-154 (1986), and must consider medical opinions of record regarding reliability of a particular study. *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131, 1-133–134 (1986). Little or no weight may be accorded to a ventilatory study if the miner exhibited "poor" cooperation or comprehension. *Houchin v. Old Ben Coal Co.*, 6 B.L.R. 1-1141 (1984); *Runco v. Director, OWCP*, 6 B.L.R. 1-945, 1-946–947 (1984); *Justice v. Jewell Ridge Coal Co.*, 3 B.L.R. 1-547, 1-551 (1981).

There are three new pulmonary function tests in the record. A review of the pulmonary function tests shows that if the tests are deemed valid, the majority of them have qualifying values. However, the validity of various tests is strongly disputed by the physicians who reviewed the results of these tests.

With regard to the July 28, 1999, pulmonary function test, Dr. Forehand concluded that it was valid. The pre-bronchodilator values were qualifying, based on the FEV1, MVV and FEV1/FVC ratio. The FVC value was not qualifying. The post-bronchodilator pulmonary function test was qualifying based on the FEV1, FVC and MVV. Dr. Michos found that the MVV was not valid because it showed suboptimal effort. The data was subsequently reviewed by various physicians. Dr. Stewart felt that the pulmonary function studies were technically valid, except for the MVV, which showed variability indicative of less than maximal effort. Dr. Hippensteel found variability in the peak expiratory flow. Dr. Morgan found that the Claimant's efforts were not reproducible and were not sustained long enough. Dr. Loudon found variability in the Claimant's effort and a marked reduction in the MVV. Dr. Fino found that the Claimant did not use maximum effort. Dr Castle found less than maximal effort on the peak flows. Based on the opinions of multiple physicians who reviewed the tracings and results, I find that the results of this test cannot be used to determine the presence of disability. The clear weight of the medical opinions suggests that the Claimant did not exhibit maximal effort on this test.

Dr. Hippensteel conducted the April 11, 2000 pulmonary function test. If the test is valid, the values would be qualifying pre-bronchodilator, but not post bronchodilator. However, Dr. Hippensteel did not believe that the test was a true measure of the Claimant's lung function, based on the Claimant's inconsistent efforts and his submaximal peak effort. He also found the MVV invalid. Dr. Fino felt that this pulmonary function test showed better effort than the July 28, 1999, pulmonary function test. Dr. Castle felt that the April 11, 2000, pulmonary function test showed less than maximal efforts and peak flows. Dr. Morgan agreed with Dr. Hippensteel's assessment, and noted that many of the tracings were aborted six to seven seconds before plateau and showed submaximal effort. Dr. Loudon felt that this test showed variability in effort with a reduction of the MVV. Based on the overwhelming weight of the physician's opinions regarding the reliability of the April 11, 2000, tests, I conclude that they are also invalid and should not be relied upon in determining whether the Claimant is totally disabled.

Due to suggestions of other physicians that the Claimant's pulmonary function tests were invalid, Dr. Forehand conducted another pulmonary function test on August 18, 2000. This test produced qualifying values, both pre- and post-bronchodilator. Dr. Forehand concluded that this test was valid, noting that the volume time and flow volume curve were smooth and consistent and were without hesitation. Dr. Hippensteel noted that there was still some variability, but the Claimant had shown better effort on this test. He felt that this pulmonary function test was valid. Both Dr. Stewart and Dr. Castle felt the pre-bronchodilator values were invalid. Dr. Stewart found a variance of more than 5% in the values, and Dr. Castle noted that the mouth piece had been partially obstructed by the Claimant's tongue. Both Dr. Stewart and Dr. Castle felt that the post-bronchodilator values were valid. Dr. Morgan felt that the pulmonary function test tracings were unacceptable. I have reviewed the opinions of the physicians, giving due note to the fact that the Claimant bears the burden of establishing all elements of entitlement. However, I conclude that at least the post-bronchodilator values on the August 18, 2000, test were both valid and qualifying. Thus, the only valid pulmonary function test was indicative of a totally disabling pulmonary or respiratory impairment. Nevertheless, I conclude that the one valid, qualifying score is insufficient in and of itself to warrant a finding of total disability.

The Arterial Blood Gas Studies

I have reviewed the two new arterial blood gas studies as well. I note that the July 28, 1999, at-rest arterial blood gas study was qualifying, but that the exercise values were not qualifying. Neither the at-rest values nor the exercise values were qualifying on the April 11, 2000, arterial blood gas studies. No physician has indicated that these studies are invalid. However, I note that the most recent arterial blood gas study was not qualifying, and that the earlier blood gas study was not qualifying at exercise. Thus, the weight of the evidence suggests that the Claimant cannot be found totally disabled based on the arterial blood gas studies.

The Reasoned Medical Opinions

Many of the physicians who examined the Claimant or reviewed the Claimant's records offered opinions as to the Claimant's capability of returning to his last coal mine employment. Dr. Forehand, who examined the Claimant and performed two pulmonary function tests and an arterial blood gas study, determined that he did not retain the capacity to return to his last coal mine employment. Dr. Hippensteel examined the Claimant and, after reviewing the results of the most recent August 18, 2000, pulmonary function test, concluded that the Claimant had a 25% whole man impairment and could do periodic heavy manual labor. Dr. Castle, who did not examine the Claimant, concluded based on the August 18, 2000, pulmonary function test that the Claimant had moderate, partially reversible airways obstruction. He did not feel that the Claimant's lung function would allow him to engage in regular heavy manual labor. Likewise, in his most recent report, Dr. Stewart reviewed the August 18, 2000, pulmonary function test. He concluded that the Claimant was permanently and totally disabled from his last coal mine employment, which involved the Claimant working on the belt line and shoveling coal eight hours a day. In contrast, Dr. Fino did not believe that the Claimant was totally disabled due to

lung disease. Dr. Morgan felt that were it not for the Claimant's age, he would be capable of carrying out his last coal mine work. He characterized the Claimant's impairment as mild to moderate. Dr. Loudon found that the Claimant had mild chronic obstructive lung disease that might possibly affect the Claimant's ability to do heavy manual labor; however, he also concluded that the Claimant was not totally disabled from his last coal mine employment.

Thus, there is divergence as to whether the Claimant's pulmonary/respiratory impairment is sufficiently severe to prevent him from performing his last coal mine employment. All physicians agree, however, that the Claimant has some degree of obstructive impairment. Thus, the Claimant does have a pulmonary/respiratory impairment. Most of the examining and reviewing physicians have characterized the Claimant's impairment as mild to moderate. Drs. Forehand, Stewart, and Castle stated unequivocally that the Claimant did not retain the respiratory capacity to return to his usual coal mine employment. Dr. Hippensteel felt the Claimant's lung function would allow him to engage in "periodic" heavy manual labor. Dr. Loudon felt the Claimant could still perform his last coal mine employment, but noted possible difficulty with heavy manual labor. Drs. Fino and Morgan unequivocally felt that the Claimant retained the respiratory capacity to perform his last coal mine work. A review of the record reveals that the Claimant's last coal mine employment did require heavy manual labor on a regular basis. Two physicians examined the Claimant. Dr. Forehand felt unequivocally that the Claimant lacked the respiratory capacity to return to his last employment. Dr. Hippensteel's finding was somewhat equivocal on the issue. The remaining physicians reviewed the Claimant's records and offered opinions. Drs. Stewart and Castle felt the Claimant was had a total pulmonary/respiratory impairment, while Drs. Fino and Morgan felt the Claimant did not have a total pulmonary/respiratory impairment. Dr. Loudon's opinion was similar to that of Dr. Hippensteel and was equivocal. The question here is one of degree of impairment, and is largely dependent on the opinion of the physicians, taking into account the extent of the Claimant's impairment and the requirements of his last coal mine employment as a beltman. I have weighed the physicians' opinions, which are close to being in equipoise. However, when these opinions are considered in conjunction with the results of the August 18, 2000, post-bronchodilator pulmonary function test, which was valid and qualifying, the scales tip definitively in favor of the Claimant. Therefore, I find that the Claimant has established that he has a totally disabling respiratory or pulmonary condition. I make no judgment as yet whether this impairment is due to pneumoconiosis, as it is medically or legally defined. As I have concluded that the Claimant has a totally disabling respiratory or pulmonary condition, however, the Claimant has established a material change in conditions since the final adjudication of his prior claim, in which Judge Rosenzweig concluded that the Claimant had not established that he had such a disability.

Accordingly, I must now reach the merits of the claim.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.
>
> (1) *Clinical Pneumoconiosis.* "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, *i.e.*, the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.
>
> (2) *Legal Pneumoconiosis.* "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2001). In this case, various physicians have opined that the Claimant has chronic obstructive pulmonary disease, which can be encompassed within the definition of legal pneumoconiosis. Ibid.; *Richardson v. Director, OWCP*, 94 F.3d 164 (4th Cir. 1996); *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995).

20 CFR § 718.202(a) (2001), provides that a finding of the existence of pneumoconiosis may be based on (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions described in §§ 718.304 (irrebuttable presumption of total disability if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982) or 718.306 (applicable only to deceased miners), or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. There is no evidence that the

Claimant has had a lung biopsy, and, of course, no autopsy has been performed. None of the presumptions apply, because the evidence does not establish the existence of complicated pneumoconiosis. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the chest x-rays and medical opinions. Absent contrary evidence, evidence relevant to either category may establish the existence of pneumoconiosis. In the face of conflicting evidence, however, I must weigh all of the evidence together in reaching my finding whether the Claimant has established that he has pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 211 (4th Cir. 2000); *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22 (3rd Cir. 1997).

Pneumoconiosis is a progressive and irreversible disease. *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 314-315 (3rd Cir. 1995); *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 803 (4th Cir. 1998); *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. *See Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp.*, 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); Stanford *v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co.*, 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148-1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, above at 319-320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

There are two new x-rays in this case. All of the readings are negative, except for one reading of the July 28, 1999, x-ray. For cases with conflicting x-ray evidence, the Regulations specifically provide,

> Where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays.

20 CFR § 718.202(a)(1) (2001); *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31, 1-37 (1991). Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985). Greater weight may be accorded to x-ray interpretations of dually qualified physicians. *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128, 1-131 (1984). A judge may consider the number of interpretations on each side of the issue, but not to the exclusion of a qualitative evaluation of the x-rays and their readers. *Woodward*, 991 F.2d at 321; *see Adkins*, 958 F.2d at 52.

The July 28, 1999, x-ray was read by Dr. Alexander as positive for pneumoconiosis, with a profusion of 1/1. Dr. Alexander is both a board-certified radiologist and a B-reader. However, the x-ray was read as 0/1 or negative by Drs. Navani, Wiot, Spitz, Wheeler, Scott and Kim, all of whom are also board-certified radiologists and B-readers, as well as by Dr. Forehand and Dr. Hippensteel, both of whom are B-readers. The majority of these physicians made similar findings of post-inflammatory changes. While Dr. Alexander's qualifications equal or exceed those of all of the other physicians, his opinion is outweighed by the contrary determination of every other physician who read the July 28, 1999, x-ray. Moreover, the interpretations of the other physicians are generally consistent with one another. Therefore, I find that the July 28, 1999, x-ray is negative for pneumoconiosis. I further note that there were no interpretations of the April 11, 2000, x-ray that were positive for pneumoconiosis. Therefore, I find that the April 11, 2000, x-ray is also negative for pneumoconiosis.

These constitute all of the x-ray interpretations in the record pertaining to Mr.Yost's duplicate claim. I have found all of them to be negative. I have also reviewed all of the x-ray readings of record in this case and concur with both Judge Feirtag and the Benefits Review Board that these x-rays also do not establish the existence of pneumoconiosis. Accordingly, Mr. Yost cannot be found to have pneumoconiosis on the basis of the x-ray evidence.

I must next consider the medical opinions. The Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149, 1-155 (1989) (en banc). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-1291, 1-1294 (1984). A physician's report may be rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co.*, 6 B.L.R. 1-1182, 1-1184 (1984). An opinion may be given little weight if it is equivocal or vague. *Griffith v. Director, OWCP*, 49 F.3d 184, 186-187 (6th Cir. 1995); *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91, 1-94 (1988); *Parsons v. Black Diamond Coal Co.*, 7 B.L.R. 1-236, 1-239 (1984).

The qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-599 (1984). More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically. *Onderko v.*

Director, OWCP, 14 B.L.R. 1-2, 1-6 (1989). However, a judge "is not required to accord greater weight to the opinion of a physician based solely on his status as claimant's treating physician. Rather, this is one factor which may be taken into consideration in . . . weighing . . . the medical evidence . . ." *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-105 (1994). Factors to be considered in weighing evidence from treating physicians include the nature and duration of the relationship, and the frequency and extent of treatment.

Dr. Forehand examined the Claimant and performed a variety of tests. He ultimately concluded, based on the Claimant's history, physical examination, and pulmonary function studies, that the Claimant had coal workers' pneumoconiosis and chronic bronchitis, which he felt was caused by the Claimant's coal dust exposure and smoking. Dr. Forehand was the only physician to conclude that the Claimant had pneumoconiosis.

In contrast, Dr. Hippensteel found that the Claimant had an obstructive disease, with no restrictive impairment. He concluded that the Claimant did not have industrial bronchitis, as industrial bronchitis resolves within months of leaving the mines. The Claimant's cough was only productive of sputum less than 25% of the time, and therefore did not meet the definition of chronic bronchitis. However, Dr. Hippensteel did feel that the Claimant had occasional bronchitis which was attributable to his smoking. Dr. Hippensteel did not find sufficient evidence of coal workers' pneumoconiosis (as it is medically or legally defined), a finding that was supported by the Claimant's lack of impairment in gas exchange and diffusion. Coal workers' pneumoconiosis affects diffusion, while bronchitis does not. Pneumoconiosis is irreversible, and the most recent pulmonary function tests showed reversibility and variability, consistent with asthma.

Dr. Fino found that the Claimant had a mild obstructive ventilatory impairment that was due to smoking. Dr. Castle did not feel the Claimant had legal or medical pneumoconiosis. Dr. Castle noted that when pneumoconiosis causes impairment, it is in the form of a mixed, irreversible obstructive and restrictive ventilatory impairment. He noted that the Claimant had no restrictive impairment, and that there was significant reversibility of the impairment. These facts led him to discount the possibility of coal workers' pneumoconiosis. This conclusion cannot be drawn with regard to pneumoconiosis as it is legally defined by the Act and the regulations. Thus, legal pneumoconiosis can cause purely obstructive impairments. However, Dr. Castle also noted that the Claimant's impairment was typical of COPD, as supported by the Claimant's hyperinflation of the lungs and gas trapping, which is the opposite of restriction but is compatible with COPD. Also weighing against a finding of coal workers' pneumoconiosis was the slight hypoxemia at rest, which resolved after exercise, and the Claimant's improvement post bronchodilator, which was inconsistent with the irreversible scarring associated with coal workers' pneumoconiosis.

Dr. Morgan also found no evidence of coal workers' pneumoconiosis, instead finding emphysema and small airways disease due to smoking. However, in his November 21, 2000, report, Dr. Morgan stated that the Claimant's decrease of FVC and FEV1 could not be attributed to coal

workers' pneumoconiosis because the Claimant had stopped working in the mines in 1973. This statement is incorrect. The Claimant last worked in the mines in 1990. Moreover, the Fourth Circuit has clearly stated, and the new regulations reflect, that pneumoconiosis is a progressive disease. Thus, Dr. Morgan's statement, even if true with regard to the Claimant's mining history, would have little probative value. Nevertheless, Dr. Morgan also noted that the Claimant's most recent pulmonary function tests showed an improvement over previous administrations of the test, and his post-bronchodilator scores reflected reversibility, neither of which is consistent with coal workers' pneumoconiosis, which is irreversible.

Dr. Loudon concluded that the Claimant had chronic obstructive lung disease due to non-occupational causes. There was insufficient evidence to diagnose coal workers' pneumoconiosis. Dr. Stewart found that the Claimant did not have coal workers' pneumoconiosis based on the negative x-rays and the lack of biopsy evidence, as well as the fact that the Claimant's smoking history could explain his current impairment. Also weighing against a finding of coal workers' pneumoconiosis was the Claimant's lack of restrictive impairment and/or rales. Dr. Stewart felt the Claimant had chronic bronchitis based on his normal diffusion capacity. Moreover, the Claimant's pulmonary function tests were consistent with smoking-induced chronic obstructive pulmonary disease.

The new medical opinions are conflicting and require a weighing process to resolve the contrary conclusions. All of the physicians who provided medical opinions did so based on adequate underlying documentation. All provided at least some rationale in support of their conclusions. Thus I consider all of these medical opinions to represent documented and reasoned medical opinions.

Both Dr. Forehand and Dr. Hippensteel examined the Claimant in connection with this duplicate claim. After weighing all of the medical opinions of record, I resolve this conflict by according greater probative weight to the opinion of Dr. Hippensteel. He possesses excellent credentials in the field of pulmonary disease and had the opportunity to examine the Claimant as well as to review other medical evidence in the record. I also find his reasoning and explanation in support of his conclusions more complete and thorough than that provided by Dr. Forehand. Dr. Forehand's diagnosis of coal workers' pneumoconiosis and chronic bronchitis due to a combination of coal dust exposure and smoking was not as well-explained. In fact, Dr. Forehand's report of the Claimant's examination does not offer any discussion regarding the reasoning behind the diagnoses, but rather only notes that the findings were based on physical examination, pulmonary function tests, and the Claimant's history. He did not explain how these factors aided his diagnoses. In contrast, Dr. Hippensteel better explained how all of the evidence he developed and reviewed supported his conclusions. He noted that the Claimant's lack of gas exchange impairment and diffusion impairment, as well as the reversible nature of his impairment, weighed against a finding of coal workers' pneumoconiosis, which is progressive and irreversible. A medical opinion which is supported by more extensive documentation is entitled to greater weight than an opinion based on more limited medical data. *Sabett v. Director, OWCP*, 7 B.L.R. 1-299, 1-301 n. 1 (1984).

I also find that Dr. Hippensteel's opinion is in better accord both with the objective medical evidence underlying his opinion and the overall weight of the medical evidence of record. A medical opinion better supported by the objective medical evidence of record is entitled to more weight. *Minnich v. Pagnotti Enterprises, Inc.*, 9 B.L.R. 1-89, 1-90 n.1 (1986). Further, additional credibility is lent to his finding of no pneumoconiosis by the detailed and reasoned opinions rendered by Drs. Stewart, Loudon, Fino, Morgan, and Castle. While none of these physicians examined the Claimant, each reviewed much or all of the medical evidence of record. Though I have previously noted flaws in the reasoning of Drs. Castle and Morgan, even their opinions generally corroborate those of Dr. Hippensteel.

In sum, I do not discredit any of the medical opinions of record. In resolving the conflict presented by the physicians of record, however, I find the opinions of Dr. Hippensteel, as supported by the conclusions of Drs. Stewart, Loudon, Fino, Morgan and Castle, to merit greater probative weight. These credible and generally well reasoned medical opinions are convincing for purposes of establishing that the Claimant does not have pneumoconiosis or any other respiratory or pulmonary impairment arising out of coal mine work. This evidence outweighs the contrary conclusions provided by Dr. Forehand. Moreover, I have reviewed the medical opinions from the Claimant's previous claims and concur with Judge Rosenzweig's opinions on remand. The medical opinions from the prior claims also support a finding of no pneumoconiosis. I conclude, therefore, that the weight of the medical opinions of record fails to establish that the Claimant has pneumoconiosis as the Act requires for entitlement to benefits.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

Because the Claimant has failed to meet his burden to establish that he has pneumoconiosis, he is not entitled to benefits under the Act.

ATTORNEY FEES

The award of an attorney's fee under the Act is permitted only in cases in which the claimant is found to be entitled to benefits. Section 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 928, as incorporated into the Black Lung Benefits Act, 30 U.S.C. § 932. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services rendered to him in pursuit of this claim.

ORDER

The claim for benefits filed by Robert N. Yost on June 25, 1999, is hereby DENIED.

A
Alice M. Craft
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 CFR § 725.481 (2001), any party dissatisfied with this decision and order may appeal it to the Benefits Review Board within 30 days from the date of this decision and order, by filing a notice of appeal with the Benefits Review Board at P.O. Box 37601, Washington, DC 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esq. Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Ave., NW, Washington, D.C. 20210.